No. 89-450

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1989

TEXAS MEDICAL ASSOCIATION, et al.,

Petitioners,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, et al.,

Respondents.

RESPONDENT'S BRIEF IN OPPOSITION TO THE PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether a necessary element of Petitioners' claims that Medicare Part B payments should not be recouped includes a challenge to the validity of a statute, regulation or instruction of the Secretary of Health and Human Services so that the issue raised by any such challenge is beyond the administrative hearing officer's adjudicative authority entitling Petitioners to judicial review of that issue.

2. Whether on an appeal from a preliminary injunction the court of appeals may order the case dismissed if an insuperable obstacle to the court's jurisdiction is clearly presented.

RULE 28.1 LISTING

Blue Cross and Blue Shield of Texas, Inc. is a parent corporation, all subsidiaries of which are wholly owned.

Group Medical & Surgical Service is an affiliate of Blue Cross and Blue Shield of Texas, Inc.

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JURISDICTION

Petitioner seeks to invoke the jurisdiction of this Court under 28 U.S.C. Section 1254(1).

STATEMENT OF THE CASE

1. Petitioners mischaracterize the record in an attempt to make their claims appear judicially reviewable.

Petitioners' statement of the case contains several inaccurate assertions. To address all of these would not assist the Court in considering the Petition.

The essence of Petitioners' complaint in this case, however, is that if Blue Cross complies with applicable law in setting the reasonable charge for the procedures in issue, then Petitioners may be required to return the windfall they received as a result of Blue Cross' earlier error in making Medicare Part B payments. They do not challenge the validity of any applicable statute, regulation or governmental policy; they challenge only the manner in which the statutes and regulations have been applied to them. Since, as discussed below, resolution of any factual issues and application of the statutes and regulations to the facts of a case are all within the authority of an administrative hearing officer, such a complaint is not judicially reviewable under the statutory scheme applicable to this case.

Judicial review is available only for those issues, such as challenges to the validity of a statute or regulation, that are beyond the adjudicative authority of a hearing officer. Thus, Petitioners have mischaracterized the record in a manner calculated to make it appear that the matters about which they complain arise from a regulation or instruction of the Health Care Financing Administration

("HCFA"), and thus fall within the ambit of judicial review.[1] Blue Cross focuses only on these inaccuracies and omissions.

2. Administrative hearings on the issues were set at the time the injunction was issued.

First, and perhaps most noticeably absent from Petitioners' statement of the case, is any mention of the fact that the administrative process that Congress established for claimants who are dissatisfied with the carrier's actions in Medicare matters was well under way in this case when the district court issued its injunction. As the court of appeals pointed out, all recipients (physicians and beneficiaries) from whom Blue Cross sought reimbursement were advised of their right to contest at an administrative hearing the determination that they had been overpaid. Blue Cross was in the process of scheduling hearings to those persons requesting them when the district court's injunction interceded. At the time of the injunction, 111 physicians and 49 beneficiaries had requested and were being set for hearings and 2,027 claims for overpayments to beneficiaries had been waived on the basis of papers submitted by them requesting hardship or without fault relief. (Tr. 22)

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[1] They also imply that the court of appeals was not aware of or did not consider certain determinative facts. This is simply not the case. As discussed in more detail below, the court of appeals carefully reviewed all of the information upon which the Petitioners rely in this Court.

The Secretary of Health and Human Services has issued no substantive instructions or directives with respect to these hearings. The issues before the hearing officer undoubtedly may include those involved in the very claims Petitioners bring in this suit: (i) whether "good cause" exists to reopen the matter, and if so, (ii) whether the claimant has been overpaid (i.e., were the amounts of payments calculated properly?), and if so, (iii) whether the claimant was "without fault" so that he might be excused from repayment liability. The hearing officer is not only able to make these determinations independently and on a case by case basis as Congress intended, he is uniquely qualified to do so.

As discussed more fully below, the only so-called "instruction" anyone at HCFA issued in this matter was that if accurate historical data existed for a procedure, then the reasonable charge should have been determined on that basis. Petitioners do not challenge the validity of this "instruction" or the statute pursuant to which it was issued. All other matters are completely within the purview of the hearing officer.

3. Neither the Secretary nor HCFA has issued any regulation or instruction concerning the calculation of the amount of benefits payable that is challenged by Petitioners.

As to the first issue raised by Petitioners concerning the calculation of the reasonable charge that governs the amount of benefits payable, contrary to Petitioners' assertion, HCFA has not in any manner usurped Blue Cross' authority to set the reasonable charge consistently with applicable law or usurped the hearing officer's power to

determine whether that was done in each case. Petitioners concede that if accurate historical data exists for a procedure, the law (42 U.S.C. § 1395u(b) (3)) requires that the reasonable charge be determined on that basis and *not* on any other, e.g., a statewide fee schedule, without regard to such data. This is not, as they suggest on pages 3 and 6 of their Petition, merely the "preferred method" or within the discretion of Blue Cross. Rather, the law by statute requires it. Carriers may use another method, after consultation with HCFA, *only* if such data does not exist. Petitioners do not challenge that law, or HCFA's responsibility for ensuring that Blue Cross complies with it.

Instead, Petitioners less than candidly assert that historical data on these procedures was "unavailable," and thus that Blue Cross had discretion to calculate the reasonable charge on the basis of a statewide fee schedule.[2] For instance, they state that when Blue Cross was implementing the data conversion that it could not accurately match its historical "customary" and "prevailing" charge data recorded under its old system with the corresponding categories in the new system, i.e., that Blue Cross had no data for the "new" categories. That statement is simply wrong.

It is undisputed that Blue Cross had accurate historical data for these procedures. II-R 201-3; III-R 295,384. It

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[2] As discussed more fully below, and as the court of appeals correctly recognized, this is precisely the type of factual determination (i.e., whether accurate historical data existed for a given procedure) that the hearings officer can and will make on a case-by-case basis.

did not move the data to the appropriate category in the new system because it was under time pressures, was receiving complaints from physicians that the conversion to the new system caused then to be underpaid, and computer programming limitations did not allow it to immediately retrieve the necessary data. III-R 295,382-4. Rather than shut down the system or continue to underpay the physicians, it elected to implement a flat statewide fee in certain of the categories knowing that paying such a fee as the reasonable charge was not in compliance with the pertinent statute but believing that the resulting payment would fall within a tolerable margin of error. Id. Blue Cross planned to spend the time to do the necessary programming work to retrieve the data in the future. III-R 383.

Indeed, after HCFA discovered that Blue Cross was not paying in accordance with the statutory dictates concerning the reasonable charge amount, Blue Cross ultimately did retrieve [not, as Petitioners state, "reconstruct"] the historical customary and prevailing charge data and place it in the appropriate categories in the new system. III-R 296. The key fact, however, which Petitioners seek to obscure is that Blue Cross did not have discretion to choose a statewide fee schedule without regard to historical data and that, in advising Blue Cross to use historical data, HCFA did nothing more than insist that Blue Cross comply with applicable statutory requirements.

Of course, in any event, if Petitioners are correct and no data existed, HCFA's so-called "instruction" that such data be used would have been futile. And, the question of whether or not Blue Cross manufactured historical data

may be resolved by a hearing officer; there has been no suggestion that HCFA issued any binding "instruction" on whether the data existed. Likewise, HCFA clearly did not prohibit Blue Cross from calculating the reasonable charge under some method other than using historical data if no data existed.

4. Neither the Secretary nor HCFA has issued any instruction on the other issues raised that is challenged by the Petitioners.

Petitioners also grossly mischaracterize in other ways the role of the government in this process. They state that HCFA "direct[ed] Blue Cross to reopen," that it "alone was responsible for all decisions," and that it "instructed Blue Cross to take virtually every step in the process and unilaterally made all the decisions." Again, those statements are incorrect.

While HCFA has directed Blue Cross to recover overpayments in appropriate cases, HCFA has never issued any blanket directives regarding whether the conditions for reopening exist in these cases or what determination should be made on the merits. As the court of appeals correctly pointed out, those are decisions to be made by the hearings officer. *Texas Medical Ass'n v. Sullivan*, 875 F.2d 1160, 1169-70 (5th Cir. 1989). Petitioners represented to the court of appeals at oral argument that documents evidencing blanket directions had been produced in discovery subsequent to the injunction hearing. That court permitted Petitioners to submit such additional documents, even though they had not been part of the record

on appeal.[3] Even after a year of discovery, however, Petitioners were unable to come up with anything to even suggest that Blue Cross was ordered to reopen all cases and collect the funds demanded regardless of whether or not the conditions for doing so exist.

Without a doubt, HCFA made the economic decision to spend the necessary funds to recoup the overpayments in accordance with applicable law. Similarly, it is undisputed that HCFA initially equivocated on that issue; it was originally thought that the amount potentially recoverable might not justify the cost. III-R 297-8. The court of appeals also recognized these facts. As that court also recognized, however, no instruction was given that would require a hearing officer to find that a file should not be reopened under the regulations if the issue is raised or that would predetermine the outcome in a particular case. Indeed, as the court of appeals concluded, HCFA "never established or even remotely declared any policies or rules which would be binding on a HO [hearing officer] called upon to determine the merits of reopening or deciding any of the individual payment claims." *Texas Medicare Ass'n v. Sullivan*, 875 F.2d at 1169, n. 29.

The only matter that has been predetermined is that Blue Cross must calculate the reasonable charge on the

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[3] Surprisingly, Petitioners actually complain on pages 22 and 23 of their Petition about having been given that opportunity. They neglect to apprise this Court, however, that the court of appeals requested such documents only *after* petitioners represented in oral argument that they had obtained documents clearly establishing their right to judicial review.

basis of accurate historical data where such data exists, rather than upon the basis of a statewide fee schedule or other basis. Petitioners have never complained about this "instruction." HCFA has not issued any instructions to the hearing officer as to how any issues should be decided, thus there is no impediment to the hearing officer's ability to decide all of the issues raised by Petitioners.

ARGUMENT

I.

NO SPECIAL OR IMPORTANT CONSIDERATIONS HAVE BEEN ADVANCED THAT WOULD WARRANT REVIEW OF THIS CASE

Petitioners raise no issues meriting the attention of this Court. As discussed below, the courts of appeal that have decided questions concerning judicial reviewability of a Medicare Part B issue since this Court's most recent decision are in accord as to the proper legal principles that should be applied. The court of appeals in this case properly applied those principles and correctly decided this case.

The parties agree, and the court of appeals properly recognized, that the legal question is whether the hearing officer has the capacity to independently – free of binding regulations and determinations of the government – hear and decide individual cases in which Blue Cross is seeking to recover overpayments. If the government promulgates some instruction that predetermines an issue in the hearing, and if a claimant challenges the validity of any

such instruction, then the court may exercise jurisdiction to decide the validity issue. Even if the government has issued some instruction that "ties the hands" of the hearing officer to some extent, however, the court is still without jurisdiction unless the plaintiff puts that instruction in issue by challenging its validity. In this case, the hearing officer is free to decide all of the issues Petitioners raise; they do not challenge the validity of any statute, regulation, or instruction. Thus the case was properly dismissed.

The factual issues raised can and should be resolved by the hearing officer. If in deciding those issues the hearing officer fails to heed the admonishment of the court of appeals in this case that the parties are to be given a "fair" hearing or refuses to decide some issue that might arise involving the validity of a binding "instuction" of the Secretary, redress will undoubtedly be available.

Moreover, since Congress in 1986 enlarged the judicial review provisions of 42 U.S.C. § 1395ff to include judicial review of most payment disputes under Part B of Medicare, the issues raised here are not likely to recur. The statutory law crucial to the decision in this case has been amended. Thus, there would appear to be little value in this Court revisiting the applicable legal principles, especially since the case was correctly decided. This is not the type of exceptional case that warrants review pursuant to Supreme Court Rule 17.

II.

THE ISSUES RAISED BY PETITIONERS ARE NOT JUDICIALLY REVIEWABLE

A. Petitioners' Complaints.

It is without dispute that the reasonable charge by which Medicare Part B payments are measured is limited by, among other things, the customary and prevailing charge for the item or service in the locality where the service is rendered pursuant to 42 U.S.C. § 1395u(b)(3). If that data is available, it must be used and a statewide fee that results in a payment beyond the statutory limit may not. Accordingly, it actually is immaterial in this case that HCFA told Blue Cross to use the customary and prevailing data if available; Blue Cross was required to do so by statute in any event.

More importantly, though, Petitioners make no challenge to the validity of the statute and thus likewise make no challenge to the validity of any direction to follow the statute. It is certainly the case that the hearing officer may not interpret the law in a way different from HCFA. That principle is irrelevant to the disposition of this appeal, however, because Petitioners do not challenge HCFA's interpretation of the law.

Instead, Petitioners raised three factual issues in the courts below: (i) whether customary and prevailing data existed in the files of Blue Cross; (ii) whether there exists an error on the face of the record or new and material evidence has been discovered; and (iii) whether the claimants were without fault in connection with the overpayment. None of these issues are difficult or extraordinary, and none is the subject of any government directive

or instruction. Thus, the court of appeals properly determined that Petitioners must pursue their administrative remedies.

1. Existence of data.

The first issue boils down to whether customary and prevailing data existed in the files by which each reasonable charge determination should have been limited in accordance with statute. As noted above, if prevailing charge data exists, then it should have been used to limit the payments made. If it did not exist, then perhaps another payment method would be proper, such as one based on a statewide fee.

Petitioners do not even suggest that HCFA has issued an "instruction" relative to the existence of prevailing charge data. For instance, HCFA clearly has not "instructed" that the hearing officer must assume that such data existed. Likewise, HCFA has not prohibited the use of the statewide fee schedule if no data exists. Indeed, as the court of appeals noted, HCFA recognized that "in the event no valid customary and prevailing charge data was available, the set statewide fees were to be retained." *Texas Medical Ass'n v. Sullivan*, 875 F.2d at 1167. In addition, the court concluded that "HCFA did not purport to determine reasonable charges for the carrier, nor did HCFA tell BCBST that after properly cross-walking or loading the valid customary and prevailing data that it could not opt to set a statewide fee for a given procedure code." Id. at 1167, n. 24. Accordingly, if the hearing officer determines that data did not exist for a given procedure, he may also determine that the statewide fee

schedule was an appropriate exercise of Blue Cross' discretion to set the reasonable charge. The hearing officer may then also determine that no overpayment was made. None of these decisions has been foreclosed by government action. Thus, this issue is not cognizable in the courts.

2. "Good cause" to reopen.

The second issue concerns whether Blue Cross had "good cause" to reopen these cases. Its resolution also depends on a factual decision. By regulation, a payment determination may be reopened when, *inter alia*, there exists an error on the face of the record on which the initial determination was based, or new and material evidence was discovered that was not considered in the initial determination. 20 C.F.R. Sec. 404.958, MCM Sec. 121007.

Again, Petitioners do not challenge these standards for allowing reopening or point to any "instruction" to a hearing officer that these cases are to be reopened regardless of whether the requirements are fulfilled. Instead, they argue that the facts do not support reopening. They contend that the customary and prevailing data was considered by Blue Cross when it decided to use statewide fees and thus does not constitute new evidence. They also argue, albeit inconsistently, that the data was not available in the files and cannot provide a basis for a determination that the payments were made based on an error on the face of the record.

As the court of appeals recognized, the question of whether the criteria for reopening exists is to be determined by the hearing officer. To satisfy itself that HCFA had issued no instruction curtailing the hearing officer's exclusive authority to make that determination, the court of appeals carefully reviewed not only the documents Petitioners relied upon in the district court, but also additional documents that Petitioners claimed at oral argument conclusively evidenced such an instruction. The court correctly concluded that HCFA "never established or even remotely declared any policies or rules which would be binding on a HO [hearing officer] called upon to determine the merits of reopening or deciding any of the individual payment claims," (*Texas Medical Ass'n v. Sullivan*, 875 F.2d at 1169, n. 29) and that "[a]bsolutely nothing in the record or supplementary documentation furnished by counsel shows that the Secretary made any interpretation of the regulations or imposed any binding instruction either supporting the existence of 'good cause' to reopen the collective or individual claims of the physicians and patients or deciding any other factor on the merits." Id. at 1169.

The hearing office has the exclusive authority to make the determination in each case where the issue is raised whether good cause exists for reopening. In these cases, that determination will be made completely independently of any instruction by the Secretary.

3. "Without fault" determination.

The third issue is whether the physicians were without fault in connection with the overpayment. If a physician is without fault in receiving an overpayment, the liability for repayment shifts to the beneficiary. See 42 U.S.C. § 1395gg(b). Again, Petitioners do not challenge the validity of any statute or regulation; rather, they argue that under the facts they are without fault and should be relieved of liability for the overpayments.

As for physicians, the Medicare Manual sets the determinative standard: he is without fault "if he exercised reasonable care in billing for and accepting the payment; i.e., he made full disclosure of all material facts, and on the basis of the information available to him, including, but not limited to, the Medicare regulations, he had a reasonable basis for assuming that the payment was correct or, if the physician had reason to question the payment, he promptly brought the question to [the carrier's] attention." MCM Sec. 7103. This test is clearly fact-intensive and appropriately within the realm of the hearing officer's authority. As with the propriety of reopening, HCFA has never issued any instructions or policies that would bind a hearing officer in determining the merits of individual payment claims, including the "without fault" issues. Accordingly, there is nothing for the court to review.

B. No Jurisdiction.

This Court has determined that these issues, which are matters for independent determination by a hearing

officer, are insulated from judicial review. For this reason, the court of appeals' dismissal should be affirmed.

In the seminal case of *United States v. Erika*, 456 U.S. 201 (1982), this Court held that 42 U.S.C. § 1395ff precluded judicial review of issues related to the amount of Part B Medicare benefits. In that case, the claimant attacked the validity of the data used to make the reasonable charge determination, urging that it was outdated. He sought to have other data used. The Court held that the issue was not reviewable since it related to the amount of benefits properly payable, a matter for independent determination by a hearing officer.

In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), on the other hand, an attack was made on the validity of Medicare regulations on constitutional and statutory grounds. The Court held that those issues related to the "method" by which the benefits "ought to be determined rather than the determinations themselves" and were subject to judicial review. Id. at 675. "Substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare Program" could be judicially reviewed. Id. at 680. The Court reasoned that since a carrier hearing officer cannot rule on such issues independently of the Secretary's directives, a claimant could not obtain any hearing whatsoever on the matter if the courts were not available to review the questions. Id. at 675-76. Conversely, if a carrier hearing officer has authority to determine the issue – independently of instructions from the Secretary that curtail that authority – then judicial review is foreclosed.

Following *Michigan Academy*, the courts of appeal have been consistent in their interpretation and application of the Court's holdings. In *McCuin v. Secretary of Health and Human Services*, 817 F.2d 161 (1st Cir. 1987), the court determined that "[b]y method challenges, the [Supreme] Court referred to 'substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare Program.'" Id. at 165. In that case, the First Circuit found that a serious constitutional challenge to the reopening regulations was advanced and held that it was reviewable. As Petitioners themselves recognize, the crux of the decision is that "the Secretary's policy controlled the intermediary's determination of [the plaintiff's] claim." The instant case is clearly distinguishable, because here the Secretary has not issued any policy or instruction that controls the hearing officer's determination of Petitioners' claims.

In *Kuritzky v. Blue Shield of Western New York, Inc.*, 850 F.2d 126 (2d Cir. 1988), *cert denied*, 109 S.Ct. 787 (1989), the court held that claims asserting that a carrier "misapplied or misinterpreted valid rules and regulations" in considering a Part B Medicare case are not judicially reviewable. The court determined that under *Michigan Academy* only claims that attack the validity of any regulation or rule promulgated by the Secretary are judicially reviewable. Thus, the court held that claims that the carrier failed to follow applicable rules and regulations in determining the reasonable charges the claimants sought were not reviewable. Similarly, in this case Petitioners have not challenged the only conceivable "rule, regulation or instruction of the Secretary" that can be found: HCFA's "instruction" that Blue Cross base its reasonable charge

determination on historical data where such data exists. All other matters, including those about which Petitioners do complain, are subject not to a HCFA instruction, but to the independent decision of the hearing officer.

Likewise, in *Association of Seat Lift Manufacturers v. Bowen*, 858 F.2d 308 (6th Cir. 1988), *cert. denied*, 109 S.Ct. 1528 (1989), the court reaffirmed that "challenges to statutes, regulations, and instructions prescribing Part B payment criteria, rather than challenges to the application of such criteria by Carriers in making Part B payment determinations, [are] the only type of challenge that could not be adjudicated in a Carrier fair hearing." Id. at 316. This case is no less a challenge to the application of payment criteria.

The court of appeals not only reached the correct result in this case, but also applied precisely those principles enunciated by this Court in *Erika* and *Michigan Academy*. First, the court recognized that these cases:

> require that we assess whether an HO has the capacity to independently – free of binding regulations and determinations of the Secretary and subordinates – to hear and decide TMA's complaints deriving from BCBST's (i) replacement of set statewide fees for the 18 codes with fee profiles which reflect valid customary and prevailing charge data, and (ii) effort to recoup overpayments made to physicians and patients while set statewide fees were used since the customary and prevailing charge data could not be retrieved by BCBST's computers.

Texas Medical Ass'n v. Sullivan, 875 F.2d at 1166. The court then proceeded to determine whether any binding regulations and determinations existed. Finding none, it properly dismissed this case.

HCFA did not by "instruction" or otherwise usurp Blue Cross' authority to make the reasonable charge determination or substitute a reasonable charge determination for Blue Cross' determination as contended by Petitioner.[4] HCFA did not by its communications with Blue Cross "prescribe the criteria" for payments; Congress prescribed the criteria and HCFA, in its supervisory capacity, sought to ensure that Blue Cross followed that criteria. Blue Cross was free to set the reasonable charge within the applicable statutory parameters. However, as reminded by HCFA and instructed by 42 U.S.C. § 1395u(b)(3), it was required to calculate and impose a ceiling on its determination in accordance with the customary and prevailing charge in the locality and was prohibited from paying more than that statutorily imposed limit. Blue Cross initially ignored the data it should have used to calculate the ceiling. When reminded of its obligation to use such data, it reviewed the customary and prevailing charge data in its files, imposed the ceiling, calculated its prior overpayment that exceeded the ceiling, and began the process of reopening the claims.

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[4] To be subject to challenge the "instruction" should be one officially issued by the Secretary. Otherwise, every direction from a HCFA employee to the carrier, even those directing the correction of clerical errors, would, if followed by the carrier, subject the matter to judicial review.

No challenge whatsoever has been advanced in this case to HCFA's "instruction" to follow the statute. This case does not even present a question of interpretation; either historical data existed, in which case it should have been used, or it did not exist, in which case the statewide fee might be used. Petitioners clearly do not challenge the criteria; their complaint, as in *Seat Lift*, pertains solely to the application of that criteria. Essentially, they are claiming that Blue Cross did not accurately review the data in its files. Such a fact bound claim can and should be reviewed by the hearing officer, and not the courts. The hearing officer has the power to set aside Blue Cross' imposition of the statutory limit in the event it is proven that no customary and prevailing charge data exists in the files or that Blue Cross misapplied HCFA's and the statute's "instructions" that the determination be limited by the customary and prevailing charge.

Likewise, as held by the court of appeals, the reopening and "without fault" claims are not reviewable. Blue Cross initiated the process of reopening the claims upon discovering that it failed to limit the charge determinations as required by statute. If no data existed in the files and Blue Cross improperly reopened, the hearing examiner may adjudicate that issue. The government has not told the hearing officer how to rule on the propriety of the reopening. As to the "without fault" claims, the agency was adjudicating those claims prior to the injunction, and will continue to do so if the injunction is finally lifted.[5] In neither case, however, is there a challenge made by the Petitioners to the validity of any statute, rule, regulation or instruction of the Secretary.

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[5] Petitioners also quibble about an insignificant refinement in the Carrier's Manual pertaining to an illustrative example of

(Continued on following page)

None of Petitioners' claims in this class action suit are judicially reviewable. The facts at issue can and should be determined by the hearing officer.

III.

THE COURT OF APPEALS PROPERLY ORDERED THE SUIT DISMISSED FOR LACK OF JURISDICTION

Although the substance of their complaint is not altogether clear, Petitioners seem to challenge the propriety of the court of appeals' action in ordering the case dismissed rather then simply vacating the injunction and remanding the case for further proceedings on the jurisdictional issue. In presenting their complaint to this Court, Petitioners are not altogether genuine. They appear surprised that the court of appeals "out of the blue" determined that there was no jurisdiction and dismissed the case before Petitioners could marshall all of their evidence.

To the contrary, however, Blue Cross briefed the issue in its initial brief to the court of appeals and requested

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when physicians are "without fault." This refinement was not effective until August, 1989, and thus its applicability to this matter is dubious. The factual standard discussed above to be applied in determining whether a physician is "without fault" remains as before and will be applied by the hearing officer. In any event, Petitioners do not challenge the validity of either the standard to be applied nor the recent change to one of the illustrative examples given.

that the court of appeals reverse the district court and dismiss the case since an insuperable obstacle to the district court's jurisdiction existed. Moreover, while the case was on appeal, Petitioners conducted extensive discovery. They had over one and one-half years to do so. And while the case was on appeal, the district court again took up the issue of judicial reviewability and denied both the Secretary's and Blue Cross' motions to dismiss for lack of jurisdiction on that question. When those motions were decided, the district court was presented with virtually the same evidence as on the preliminary injunction. Had Petitioners held any additional evidence they would surely have produced it then.

Indeed, the question of additional evidence in the hands of Petitioners arose at oral argument in the court of appeals when Petitioners' counsel told the court he had uncovered additional proof in the course of discovery to bolster his argument that the issues raised were judicially reviewable. Although counsel never specified the evidence that he uncovered, that statement prompted the court of appeals to ask the parties to submit any additional materials they had on the jurisdiction of the court to review the issues. At the time Petitioners submitted nothing that would render those issues reviewable and in their petition to this Court they likewise identify nothing that could alter the result of the court of appeals' decision. They simply belatedly complain that they should be afforded more time to find it.

This case is not unique. If a court determines that jurisdiction is lacking, as here, the case should be dismissed. *E.g, United States v. Corrick,* 298 U.S. 435 (1936) (on appeal from preliminary injunction appellate court

should correct the error in the lower court of entertaining suit when it lacks jurisdiction); *Myers v. Bethlehem Shipbuilding Corp.*, 303 U.S. 41 (1938) (where district court had no jurisdiction to issue injunction, appellate court should order case dismissed); *Meccano, Ltd. v. John Wanamaker*, 253 U.S. 136 (1920) (if on appeal it appears that an insuperable obstacle appears to the maintenance of the suit the case should be ordered dismissed).

In this case an insuperable obstacle to the maintenance of this suit exists – the issues raised are not judicially reviewable. Petitioners have simply not challenged the validity of any statute, regulation or instruction of the Secretary. All of the issues as framed by Petitioners may be determined by the hearing officer. No amount of additional discovery can change that.[6] The recoupment process, including the holding of any necessary administrative hearings, should be recommenced without further delay. In the unlikely event that during the hearing process the hearing officer rules that he cannot decide an issue because of a binding instruction from the Secretary, Petitioners could then challenge the validity of that instruction in court if they have grounds to do so.

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[6] Petitioners also suggest that some fact questions exist as to the reviewability issue, without specifying what they are. It is difficult to envision what fact issue could possibly exist.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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